MEDICAL CONTESTED CASE HEARING NO. 16005

DECISION AND ORDER

This case is decided pursuant to Chapter 410 of the Texas Workers' Compensation Act and the Rules of the Texas Department of Insurance, Division of Workers' Compensation. For the reasons discussed herein, the Hearing Officer determines that Claimant has proven that the preponderance of evidence is contrary to the Independent Review Organization (IRO) opinion that left knee arthroscopy, meniscal surgery and chondroplasty are not health care reasonably required for the compensable injury of (Date of Injury).

STATEMENT OF THE CASE

A prehearing for this medical contested case hearing was held on July 27, 2015. On September 30, 2015, Phillip Brown, a Division hearing officer, held a medical contested case hearing to decide the following disputed issue:

> Is the preponderance of the evidence contrary to the decision of the IRO that the claimant is not entitled to left knee arthroscopy, meniscal surgery and chondroplasty for the compensable injury of (Date of Injury)?

PARTIES PRESENT

Claimant/Petitioner appeared and was assisted by TB, ombudsman. Self-Insured/Respondent was appeared and represented by DW, attorney.

EVIDENCE PRESENTED

The following witnesses testified:

For the Claimant: Claimant and Dr. LD (by telephone)

For the Self-Insured: None

The following exhibits were admitted into evidence:

Hearing Officer's Exhibits: HO-1 through HO-3

Claimant's Exhibits; C-1 though C-20

Self-Insured's Exhibits: CR-A through CR-G

DISCUSSION

According to the evidence, Claimant is a (age)-year old female who sustained a compensable injury to her knees on (Date of Injury), and developed complaints of bilateral knee pain. On October 11, 2007, she underwent an arthroscopy followed by a partial lateral meniscectomy and chondroplasty involving the patella of the right knee, as well as a partial lateral meniscectomy at the left knee. Claimant reported a good result in the right knee following surgery, but she experienced continuing problems with her left knee. The evidence reflected that Claimant underwent a second arthroscopy on July 16, 2013 that included a revision partial lateral meniscectomy along with chondroplasty and microfracture of the lateral femoral condyle of the left knee. Post-operative therapy did not relieve the pain or improve her condition. According to Claimant's credible testimony, the condition of her left knee has progressed to the point where, on some days, she cannot walk. Claimant testified that she has not sustained any trauma to her left knee since the date of the compensable injury and, according to her treating doctor, Dr. ML, there was no evidence of a new injury on the MRIs of the left knee since the 2007 injury but rather, the knee had progressively deteriorated as a result of the injury. Dr. L referred Claimant to Dr. LD for an orthopedic surgical consultation. Dr. D recommended that Claimant have a third arthroscopy done to determine the cause of the on-going internal complaints of knee pain that were limiting the range of motion in the knee and use of the leg and to treat (debride) whatever he determined to be the cause of the internal knee pain.

Texas Labor Code Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Health care reasonably required is further defined in Texas Labor Code Section 401.011 (22a) as health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence based medicine or, if evidence based medicine is not available, then generally accepted standards of medical practice recognized in the medical community. Health care under the Texas Workers' Compensation system must be consistent with evidence based medicine if that evidence is available. Evidence based medicine is further defined in Texas Labor Code Section 401.011 (18a) to be the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts and treatment and practice guidelines. The Commissioner of the Division of Workers' Compensation is required to adopt treatment guidelines that are evidence-based, scientifically valid, outcome-focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Texas Labor Code Section 413.011(e). Medical services consistent with the medical policies and fee guidelines adopted by the commissioner are presumed reasonable in accordance with Texas Labor Code Section 413.017(1).

In accordance with the above statutory guidance, the Division of Workers' Compensation has adopted treatment guidelines by Division Rule 137.100. This rule directs health care providers to provide treatment in accordance with the current edition of the Official Disability Guidelines (ODG), and such treatment is presumed to be health care reasonably required as defined in the Texas Labor Code. Thus, the focus of any health care dispute starts with the health care set out in the ODG. Also, in accordance with Division Rule 133.308(s), "A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing, the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence."

Pertinent to this case, the ODG provides as follows:

> Arthroscopy
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> Definition: An arthroscope is a tool like a camera that allows the physician to see the inside of a joint, and the surgeon is sometimes able to perform surgery through an arthroscope, which makes recovery faster and easier.
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> Arthroscopic surgery for osteoarthritis
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> Not recommended. Arthroscopic lavage and debridement in patients with osteoarthritis of the knee is no better than placebo surgery, and arthroscopic surgery provides no additional benefit compared to optimized physical and medical therapy. (Kirkley, 2008) (Marcus, 2002) (Moseley, 2002) In the Meniscal Tear in Osteoarthritis Research (METEOR) trial, there were similar outcomes from PT versus surgery (Katz, 2013) In this RCT, arthroscopic surgery was not superior to supervised exercise alone after non-traumatic degenerative medial meniscal tear in older patients. (Herrlin, 2007) Another systematic review concluded that arthroscopic surgery for degenerative meniscal tears and mild or no osteoarthritis provided no benefit when compared with nonoperative management. (Khan, 2014) See also Meniscectomy, Physical therapy vs. surgery. Arthroscopic surgery in the presence of significant knee OA should only rarely be considered for major, definite and new mechanical locking/catching (i.e., large loose body) after failure of non-operative treatment. See also Loose body removal surgery (arthroscopy); Knee joint replacement; Osteotomy.
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> Other guidelines: According to the National Institute for Clinical Excellence (NICE) guidelines, arthroscopic lavage and debridement should not be offered as part of treatment for OA, unless a patient suffers from knee OA with a clear history of mechanical locking associated with intraarticular loose bodies or meniscal tears, emphasizing the importance of proper patient selection. Contrarily, the most recent AAOS guidelines indicate that arthroscopic

debridement or lavage is just not recommended for patients with primary diagnosis of symptomatic OA of the knee. Consequently, 27% of orthopaedic surgeons still recommend arthroscopy for the treatment of OA, but this treatment was found to be significantly more popular outside of the United States. (Abu-Ghanem, 2015)

Meniscectomy

Recommended as indicated below for symptomatic meniscal tears for younger patients and for traumatic tears. Not recommended for osteoarthritis (OA) in the absence of meniscal findings, or in older patients with degenerative tears until after a trial of PT/exercise. (Kirkley, 2008) (Khan, 2014) Meniscectomy is a surgical procedure associated with a high risk of knee osteoarthritis (OA). One study concludes that the long-term outcome of meniscal injury and surgery appears to be determined largely by the type of meniscal tear, and that a partial meniscectomy may have better long-term results than a subtotal meniscectomy for a degenerative tear. (Englund, 2001) Another study concludes that partial meniscectomy may allow a slightly enhanced recovery rate as well as a potentially improved overall functional outcome including better knee stability in the long term compared with total meniscectomy. (Howell-Cochrane, 2002) The following characteristics were associated with a surgeon's judgment that a patient would likely benefit from knee surgery: a history of sports-related trauma, low functional status, limited knee flexion or extension, medial or lateral knee joint line tenderness, a click or pain noted with the McMurray test, and a positive Lachmann or anterior drawer test. (Solomon, 2004) Our conclusion is that operative treatment with complete repair of all torn structures produces the best overall knee function with better knee stability and patient satisfaction. In patients younger than 35, arthroscopic meniscal repair can preserve meniscal function, although the recovery time is longer compared to partial meniscectomy. Arthroscopy and meniscus surgery will not be as beneficial for older patients who are exhibiting signs of degenerative changes, possibly indicating osteoarthritis, and meniscectomy will not improve the OA. Meniscal repair is much more complicated than meniscal excision (meniscectomy). Some surgeons state in an operative report that they performed a meniscal repair when they may really mean a meniscectomy. A meniscus repair is a surgical procedure done to repair the damaged meniscus. This procedure can restore the normal anatomy of the knee, and has a better long-term prognosis when successful. However, the meniscus repair is a more significant surgery, the recovery is longer, and, because of limited blood supply to the meniscus, it is not always possible. A meniscectomy is a procedure to remove the torn portion of the meniscus. This procedure is far more commonly performed than a meniscus repair. Most meniscus tears cannot be treated by a repair. See also Meniscal allograft transplantation. (Harner, 2004)

(Graf, 2004) (Wong, 2004) (Solomon-JAMA, 2001) (Chatain, 2003) (Chatain-Robinson, 2001) (Englund, 2004) (Englund, 2003) (Menetrey, 2002) (Pearse, 2003) (Roos, 2000) (Roos, 2001) Arthroscopic debridement of meniscus tears and knees with low-grade osteoarthritis may have some utility, but it should not be used as a routine treatment for all patients with knee osteoarthritis. (Siparsky, 2007) Asymptomatic meniscal tears are common in older adults, based on studying MRI scans of the right knee of 991 randomly selected, ambulatory subjects. Incidental meniscal findings on MRI of the knee are common in the general population and increase with increasing age. Identifying a tear in a person with knee pain does not mean that the tear is the cause of the pain. (Englund, 2008) Arthroscopic meniscal repair results in good clinical and anatomic outcomes. (Pujol, 2008) Whether or not meniscal surgery is performed, meniscal tears in the knee increase the risk of developing osteoarthritis in middle age and elderly patients, and individuals with meniscal tear were 5.7 times more likely to develop knee osteoarthritis. (Englund, 2009) AHRQ Comparative Effectiveness Research concluded that arthroscopic lavage for osteoarthritis, with or without debridement, does not improve pain and function for people with OA of the knee. (AHRQ, 2011) The repair of meniscal tears is significantly improved when performed in conjunction with ACL reconstruction. (Wasserstein, 2011) In patients with a nontraumatic degenerative medial meniscal tear and no knee osteoarthritis, arthroscopic partial meniscectomy is no better than sham surgery according to a high quality RCT. While arthroscopic partial meniscectomy is the most common orthopedic procedure performed in the U.S., rigorous evidence of its efficacy is lacking. While the results may argue against the current practice of performing arthroscopic partial meniscectomy in patients with a degenerative meniscal tear, the study did not compare meniscectomy with no treatment, because in the sham surgery group, they inserted an arthroscope and put fluid through the knee. (Sihvonen, 2013)

Physical therapy vs. surgery: In older patients with degenerative tears and symptoms caused by osteoarthritis, PT/exercise may be an appropriate first option and it may be possible to reserve surgery for those who do not benefit from PT alone. A high quality RCT, the Meniscal Tear in Osteoarthritis Research (METEOR) trial, found similar outcomes from PT versus surgery for meniscal tears in older individuals. Researchers at seven major universities and orthopedic surgery centers around the U.S. assigned 351 people with arthritis and meniscus tears to get either surgery or physical therapy, nine sessions on average plus exercises to do at home. After six months, both groups had similar rates of functional improvement, and pain scores were also similar. While 30% of patients assigned to physical therapy wound up having surgery before the six months was up, often because they felt therapy wasn’t helping them, they ended up the same

as those who got surgery right away, as well as the rest of the physical therapy group who stuck with it and avoided having an operation. These results suggest that physical therapy may be an appropriate first option for many patients with osteoarthritis and meniscal tears and that it may be possible to reserve surgery for those who do not benefit from physical therapy alone. (Katz, 2013) Another RCT comparing meniscectomy to strengthening exercises in patients presenting with degenerative medial meniscus tear and no clear evidence of osteoarthritis (Kellgren-Lawrence grade 0-1) found no significant between-group differences in function, pain, or patient satisfaction scores. (Yim, 2013) Arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical and medical therapy, according to the results of a single-center, RCT reported in the *New England Journal of Medicine*. The study, combined with other evidence, indicates that osteoarthritis of the knee (in the absence of a history and physical examination suggesting meniscal or other findings) is not an indication for arthroscopic surgery and indeed has been associated with inferior outcomes after arthroscopic knee surgery. However, osteoarthritis is not a contraindication to arthroscopic surgery, and arthroscopic surgery remains appropriate in patients with arthritis in specific situations in which osteoarthritis is not believed to be the primary cause of pain. (Kirkley, 2008) In this RCT, arthroscopic partial medial meniscectomy followed by supervised exercise was not superior to supervised exercise alone in terms of reduced knee pain, improved knee function and improved quality of life, after non-traumatic degenerative medial meniscal tear in ninety patients, mean age 56 years. (Herrlin, 2007) (Marcus, 2002) (Moseley, 2002) See also Arthroscopic surgery for osteoarthritis; Loose body removal surgery (arthroscopy).

Risk versus benefit: The advantage of most surgery to treat meniscus tears appears to be limited to short term relief of pain and mechanical catching, but not prevention of eventual osteoarthritis. Due to loss of meniscal cushioning following acute traumatic tears with or without additional removal of meniscal tissue (partial meniscectomy), OA progression simply becomes inevitable. Primary surgical repair of meniscus tears when feasible offers the best hope of joint preservation, but is associated with the risks of slower recovery and a relatively high re-tear rate often requiring additional surgery. The benefit of surgery for atraumatic tears or in the presence of significant OA drops off dramatically and may even be harmful, further accelerating OA progession. The ideal patients for meniscus surgery are younger, with smaller or repairable traumatic tears associated with mechanical symptoms, and no associated OA. Due to the unsolved issue of OA progession despite surgery, many indications for surgery in the past are now being questioned.

ODG Indications for Surgery -- Meniscectomy:

Criteria for meniscectomy or meniscus repair (Suggest 2 symptoms and 2 signs to avoid scopes with lower yield, e.g. pain without other symptoms, posterior joint line tenderness that could just signify arthritis, MRI with degenerative tear that is often false positive). Physiologically younger and more active patients with traumatic injuries and mechanical symptoms (locking, blocking, catching, etc.) should undergo arthroscopy without PT.

1. Conservative Care: (Not required for locked/blocked knee.) Exercise/Physical therapy (supervised PT and/or home rehab exercises, if compliance is adequate). AND (Medication. OR Activity modification [eg, crutches and/or immobilizer].) PLUS
2. Subjective Clinical Findings (at least two): Joint pain. OR Swelling. OR Feeling of give way. OR Locking, clicking, or popping. PLUS
3. Objective Clinical Findings (at least two): Positive McMurray's sign. OR Joint line tenderness. OR Effusion. OR Limited range of motion. OR Locking, clicking, or popping. OR Crepitus. PLUS
4. Imaging Clinical Findings: (Not required for locked/blocked knee.) Meniscal tear on MRI (order MRI only after above criteria are met). (Washington, 2003)

For average hospital LOS if criteria are met, see Hospital length of stay (LOS).

Chondroplasty

Recommended as indicated below. Not recommended as a primary treatment for osteoarthritis, since arthroscopic surgery for knee osteoarthritis offers no added benefit to optimized physical therapy and medical treatment. (Kirkley, 2008) See also Meniscectomy.

ODG Indications for Surgery -- Chondroplasty:

Criteria for chondroplasty (shaving or debridement of an articular surface), requiring ALL of the following:

1. Conservative Care: Medication. OR Physical therapy. PLUS
2. Subjective Clinical Findings: Joint pain. AND Swelling. PLUS
3. Objective Clinical Findings: Effusion. OR Crepitus. OR Limited range of motion. PLUS
4. Imaging Clinical Findings: Chondral defect on MRI

(Washington, 2003) (Hunt, 2002) (Janecki, 1998)

The exceptions to ODG treatment recommendations are set out in Appendix D to the ODG. Appendix D provides:

> "The purpose of this section is to outline a process so patients can receive appropriate medical treatment even if it is not covered in ODG. As explained on the Copyright Page:
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> These publications are guidelines, not inflexible proscriptions, and they should not be used as sole evidence for an absolute standard of care. Guidelines can assist clinicians in making decisions for specific conditions and also help payors make reimbursement determinations, but they cannot take into account the uniqueness of each patient's clinical circumstances."

"There will be situations where injured workers will need medical care outside of the guidelines. There are a variety of ways that this can be achieved, including understandings, both formal and informal, where an insurance carrier and a provider have agreed, as a result of proven outcomes and adherence to evidence-based treatment guidelines from that provider that the insurance carrier will defer to the provider's recommendations ***** "In cases where the medical care is an exception to ODG, the health care provider should document: (1) extenuating circumstances of the case that warrant performance of the treatment including the rationale for procedures not addressed in ODG; (2) patient co-morbidities, (3) objective signs of functional improvement for treatment conducted thus far; (4) measurable goals and progress points expected from additional treatment; and (5) additional evidence that supports the health care provider's case. The process for documenting exceptions to guidelines is supported by medical research. According to a study published in the February 2010 edition of the *Annals of Internal Medicine*, funded by the Agency for Healthcare Research and Quality, exceptions to treatment guidelines that are documented by physicians during their regular workflow and reviewed by peers are appropriate most of the time. Of over 600 exceptions to the treatment guidelines, 94% (95% CI, 91.4% - 95.4%) were determined to be medically appropriate, 3% were inappropriate, and 3% were of indeterminate appropriateness. When physicians report exceptions to standard practices, it affirms their ability to make decisions and helps them aim for high performance levels while avoiding treatment delays, study authors noted. (Persell, 2010)

> If ODG does not support the health care provider's recommendation, there may be two reasons for this:
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> A. Situations not addressed in the guidelines
> B. Treatments that are covered but not recommended

A. Situations not addressed in the guidelines

1. Conditions not commonly seen in workers' compensation.

ODG already covers over 99% of medical conditions seen in workers' compensation, but it does not cover many common conditions seen outside of workers' compensation, such as diabetes, cancer, heart disease, cosmetic surgery, etc. There may be instances where a treatment that is typically not used in the occupational injury arena is indicated for a particular occupational injury. This may be reasonable either based on evidence from the non-occupational injury arena; or in the absence of adequate evidence, a reasonable clinical rationale. In making clinical decisions for conditions not covered by ODG, or for treatments not mentioned in ODG, health care providers should rely on the medical evidence as much as possible.

2. Documenting functional improvement & patient co-morbidities

In those situations where the treatment at issue is not addressed in ODG, the health care provider should demonstrate how functional improvement would be the expected result of the treatment. Providers should also document any relevant co-morbidities (if applicable) that may increase the likelihood that this treatment would be appropriate for their patient.

B. Treatments that are covered but not recommended

When a treatment and condition are already covered in ODG, but specifically not recommended in ODG (or ODG has a patient selection criteria that would not include the case under consideration), the health care provider requesting the treatment should provide documentation specific to his or her case to support the use of the treatment outside of the guidelines. This is because the highest quality scientific evidence for this situation should already be in the guidelines, so it would not be likely to find evidence that could trump the evidence already in the guidelines. Patients with co-morbidities and/or documented functional improvement warrant additional consideration and the health care provider should adequately document these factors if present.

1. Patient co-morbidities

In documenting why their patient may be an exception to the guidelines, providers will want to explain how their patient is different from the ones used in the studies that may have resulted in a negative recommendation or exclusion. Co-morbidities may also require additional treatments beyond ODG recommendations. This will typically involve co-morbidities, for example, obesity, or diabetes that may increase the likelihood that this treatment would be appropriate for their patient. This may also include vocational, recreational and/or

other functional factors. There could be specifics of the injury or condition that put the injured worker outside of the type of patients covered in the high quality studies.

2. Documenting functional improvement

A significant goal of any medical treatment in the workers' compensation system is to return the patient to his prior level of function to allow injured workers to go back to the life they had prior to injury, including return to work. The provider should demonstrate how this functional improvement would be the expected result of the treatment in this case, either from past experience or from an explanation about the mechanism of injury and the effect of the treatment, and documenting points where this improvement can be measured."

The IRO decision to uphold the denial of the requested medical care as not being medically necessary was premised on a belief that osteoarthritis was the cause of Claimant's ongoing left knee pain and, further, that the purpose of the requested arthroscopy was to treat such osteoarthritis in contradiction of ODG recommendations. Dr. D's March 23, 2015 report, however, indicated that the purpose of the proposed surgery was not to treat osteoarthritis but rather, to diagnose and treat a lateral joint line collapse in flexion with a greater degree of patellofemoral arthropathy on the left side of the knee (C-8, p. 1). At the hearing, Dr. D explained why osteoarthritis was not the primary pain generator in Claimant's left knee. According to this testimony, the goal of the proposed surgery was to improve the interior of Claimant's knee in order to improve the quality of her life through better functioning while forestalling an eventual total knee replacement.

Regarding the medical necessity for the requested procedures, Dr. D pointed to the appearance of a new complex medial meniscal tear in the posterior horn which had not been present in earlier MRIs, his clinical findings, radiologic findings taken at his clinic, and Claimant's lack of improvement from past therapy and medications as the bases for his surgery recommendation. The evidence indicated that the proposed treatment would be the third procedure to address continuing problems with Claimant's left knee. Dr. D was persuasive in his testimony that the ODG treatment guidelines for arthroscopy did not fit the facts of this case. The doctor's testimony reflected that the recommended treatment was within the common practice in his area, as reflected in the 2008 Kirkley study cited in Dr. L's causation letter for the proposition that osteoarthritis is not a contraindication to arthroscopic surgery in situations where, as in this case, it is not thought to be the primary cause of the knee pain. Claimant's evidence, including consideration of Appendix D of the ODG and Dr. D's testimony, is sufficient to show that the treatment at issue is health care reasonably required for her compensable injury.

Based on the overall evidence, I find that Claimant has met her burden to show that the preponderance of evidence is contrary to the IRO opinion that left knee arthroscopy, meniscal

surgery and chondroplasty are not health care reasonably required for the compensable injury of (Date of Injury).

The Hearing Officer considered all of the evidence admitted. The Findings of Fact and Conclusions of Law are based on an assessment of all the evidence whether or not the evidence is specifically discussed in this Decision and Order.

FINDINGS OF FACT

1. The parties stipulated to the following facts:

   A. Venue is proper in the (City) Field Office of the Texas Department of Insurance, Division of Workers' Compensation.

   B. On (Date of Injury), Claimant was the employee of (Employer), Employer.

   C. On (Date of Injury), Employer provided workers' compensation insurance as a certified Self-Insured.

   D. On (Date of Injury), Claimant sustained a compensable injury.

   E. The Independent Review Organization, P-IRO, Inc., determined that Claimant should not have a left knee arthroscopy, meniscal surgery and chondroplasty.

2. Self-Insured delivered to Claimant a single document stating the true corporate name of Self-Insured, and the name and street address of Self-Insured's registered agent, which document was admitted into evidence as Hearing Officer's Exhibit Number 2.

3. The preponderance of evidence is contrary to the IRO opinion that left knee arthroscopy, meniscal surgery and chondroplasty are not health care reasonably required for the compensable injury of (Date of Injury).

CONCLUSIONS OF LAW

1. The Texas Department of Insurance, Division of Workers' Compensation, has jurisdiction to hear this case.

2. Venue is proper in the (City) Field Office.

3. The preponderance of the evidence is contrary to the decision of the IRO that left knee arthroscopy, meniscal surgery and chondroplasty are not health care reasonably required for the compensable injury of (Date of Injury).

DECISION

Claimant is entitled to treatment in the form of left knee arthroscopy, meniscal surgery and chondroplasty for the compensable injury of (Date of Injury).

ORDER

Self-Insured is liable for the benefits at issue in this hearing. Claimant also remains entitled to medical benefits for the compensable injury in accordance with §408.021

The true corporate name of Self-Insured **(EMPLOYER),** and the name and address of its registered agent for service of process is:

CT CORPORATION SYSTEM
1999 BRYAN STREET, SUITE 900
DALLAS, TX 75201-3136

Signed this 16th day of October, 2015.

Phillip Brown
Hearing Officer